Guide Attachment A for local program use.
If a local intake form and systems are in use and effective, the essential CDBG COVID-19 specific information from this form should be added to ensure all required information is collected and documented.

Lower Columbia CAP

Community Development Block Grant Program (CDBG) COVID-19
Utility/Rent/Mortgage Subsistence Payment - Application and Verification Form

Up to $275,097.88 total is available to qualifying families impacted by COVID-19 for emergency subsistence payments. To request assistance, you must meet the program requirements, submit required documentation, and certify this form before January 31, 2023.

Funds are available on a limited basis. Submitting this application is not a guarantee of assistance. For your privacy, information collected will remain confidential, used only to meet federal and state record keeping requirements, and withheld as applicable from disclosure.

Please print:

Name(s)			
Residential Address		**Phone**	
Email		**Total Amount Requested**	$
Make payment on my behalf to:			
Name		**Phone or Email**	
Address/Account#			
Proposed Use of Funds	☐ Water Utility ☐ Sewer Utility ☐ Rent ☐ Mortgage ☐ Other: _____		
Month(s) to Cover		**Amount**	$
Name		**Phone or Email**	
Address/Account#			
Proposed Use of Funds	☐ Water Utility ☐ Sewer Utility ☐ Rent ☐ Mortgage ☐ Other: _____		
Month(s) to Cover		**Amount**	$

	Data	**YES**	**NO**
DUPLICATION OF BENEFIT – Have you received, or are aware of being eligible to receive from another source, any financial assistance for the costs listed above, and would the total amount received exceed the total need for those costs?		☐	☐
COVID-19 IMPACT – Have you had work hours reduced, been temporarily or permanently laid off, or other loss of income due to COVID-19? If **YES**, provide details: _____	EST. % loss of revenue from one year previous: _____%	☐	☐
SUBSISTENCE/EMERGENCY STATUS – Have you received a late payment due, eviction notice or other proof that loss of housing or essential utility services is at risk and emergency payment need?	Number of months unable to pay: _____	☐	☐

LMI Household Income Qualification Questions						
Total Annual Household Income is gross income (before deductions) from all sources of income (wages, child support, SSI, unemployment, pension, income from assets, etc.), from all adult members in the family living in the household. Consult the program if unsure.						
Total Household Income anticipated during the next 12 months						
Name List all household members, including yourself.	**Age**	***Check if Applicable***			**Annual Gross (Pre-Tax) Income**	**Source of Income**
		Head of House-hold	**Co-Head of House-hold**	**Full Tm Student 18 Yrs. or Older**		
					$	
					$	
					$	
					$	
					$	
Add rows as applicable					$	
Total Anticipated Annual Household Income:					$	

***CIRCLE* the number of Household Members, including yourself:**							
1	**2**	**3**	**4**	**5**	**6**	**7**	**8+**
insert county 80% **$**	*insert county 80%* **$**	*insert county 80%* **$**	*insert county 80%* **$**	*insert county 80%* **$**	*insert county 80%* **$**	*insert county 80%* **$**	*insert co 80%* **$**
Is your **anticipated** total household income **LOWER** or **HIGHER** than the $ amount listed directly below the number of people circled above? If **LOWER**, attach proof of annual household income (such as latest tax return, quarterly tax, pay stubs, or bank statements).						**LOWER** ☐	**HIGHER** ☐
Ethnicity *enter numbers to equal Household Members*				**#____Not Hispanic**		**#____Hispanic**	

Race *enter numbers to equal Household Members*			
White	**#**	Asian	**#**
Black or African American	**#**	Native Hawaiian or Pacific Islander	**#**
American Indian or Alaskan Native	**#**	Asian and White	**#**
American Indian/Alaskan Native and White	**#**	Black/African American and White	**#**
American Indian/Alaskan Native and Black/African America	**#**	Other Multi-Racial	**#**

Applicant Certification: *I certify information given on this form is true and accurate to the best of my knowledge. I am aware there are penalties for willfully and knowingly giving false information. I authorize verification by government representatives, and I will provide additional supporting documentation upon request.*

Client Name (Verbal Consent Allowed)**:** _____ Date/Time:_____

Agency Staff please print and sign here**:** _____ Date/Time:____

Household LMI Qualification Verified: _____Staff initials/date: _____
Duplication of Benefit Prevented: _____ Staff initials/date: _____
Funding Approval: _____Manager initials/date: _____
Account Number: _____ Approved Amount: _____